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THE ANG SECOND ECHELON MEDICAL
MISSION AND TRAINING REQUIREMENTS

MAJOR TIMOTHY M. ADAMS 88-0030

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REPORT NUMBER 88-0030

TITLE THE ANG SECOND ECHELON MEDICAL MISSION AND TRAINING
REQUIREMENTS

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PREFACE

Much has been written about the readiness of the US Air Force flying units, its personnel and training requirements. Included in this are mission support units directly involved in maintaining the aircraft or supporting communicative type units. Little has been written about the particular medical mission of the Air National Guard (ANG) in support of the US Air Force (USAF).

The Air National Guard is responsible for over 50% of the second echelon (2E) medical mission of US Air Force. The limited information on this subject is in Air Force regulations and war mobilization plans. This paper explains how this mission of the ANG relates to the USAF wartime medical mission, describes the necessary personnel and training requirements, and makes recommendations for accomplishing this to be ready for the 2E wartime mission.

Appreciation must be given to Colonel (Ret) James D. Weaver for his tutelage, Colonel D.J.E. Strate and Colonel Duane Gilbertson for their assistance, and Lt. Col. John Perrigo for his advice. Special thanks to my wife, Susan and children, Tamara and Christian for their support and patience during this project.



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ABOUT THE AUTHOR

Major Timothy Adams has over 12 years experience as a military officer in the United States Air Force. He earned a Diploma in Nursing from York School of Nursing in 1972, a Bachelor of Science in Business Administration/Economics from Rollins College in 1977, and a Master of Science in Management from Troy State University in 1980. From 1982 to 1987, Major Adams was assigned to the National Guard Bureau in the Air Surgeon's office as Chief, Medical Resource Management and subsequently, as Chief, Medical Plans and Readiness. Responsibilities included developing policy for administering and managing the fiscal and materiel requirements and expenses for 91 Air National Guard medical treatment facilities and nine Aeromedical Evacuation units. He managed the Air National Guard (ANG) medical wartime planning function, the ANG professional medical education program, formal training, and medical unit training for over 4500 medical personnel. In the medical plans and readiness office he developed implementation policy for all medical plans and readiness initiatives in the ANG; coordinated with DOD, HQ USAF, Air Force Major Commands and the States on issues involving medical wartime mobilization of ANG medical resources in support of US Air Force medical wartime mission requirements. He managed unit annual training programs, overseas deployments, and special Air Force medical taskings for the 101 ANG Medical/Aeromedical Evacuation units.

Major Adams has written or contributed to the writing of numerous regulations. Germane to this paper are ANGR 169-01, ANG Annual Medical Training Program, and AFR 160-25, Medical Readiness Planning and Training. He lectured at readiness conferences and symposiums for HQ USAF/SG, the major Air Force commands, and programs sponsored by the School of Health Care Sciences as an authority on medical readiness issues especially as they pertain to the Reserve Forces. Major Adams was involved in the development and beginning implementation of the second echelon medical concept in the Air National Guard. He initiated the unit type code (UTC) the ANG and Air Force Reserve use to support this mission.

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EXECUTIVE SUMMARY

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REPORT NUMBER 88-0030

AUTHOR(S) MAJ TIMOTHY M. ADAMS, PAANG

TITLE THE ANG SECOND ECHELON MEDICAL MISSION AND TRAINING REQUIREMENTS

- I. Purpose: To identify the means for the Air National Guard (ANG) medical units to accomplish required readiness training for the second echelon (2E) medical mission.
- II. Problem: The ANG 2E medical mission includes requirements for Continuing Medical Readiness (CMR) training and working in a Survivable Collective Protective System - Medical (SCPS-M) during wartime. Acceptance of this mission requires an examination of how to provide the means to accomplish the training and an environment similar to the SCPS-M to insure mission capability.
- III. Data: The 67 ANG medical units on mobility status completed medical readiness in a piecemeal fashion. The Inspector General's Health Services Management Inspection teams' satisfactory management rating of the majority of these did not

depict 2E mission capability. With the advent of 70 hours of CMR training, 24.6 units would not survive in wartime situations. There is only one SCPS-M available which is located in Spangdahlem, Germany. Time available to the units is 48 unit training assemblies (UTA's) per year and 15 days annual training. With peacetime support, designated annual training deployments, and ancillary training requirements, 44 hours remain to accomplish readiness and mobility training.

IV. Conclusions: The ANG 2E medical mission has created additional realistic readiness and environmental training. A disconnect has occurred in available time, facilities, and requirements.

V. Recommendations: The Office of the Air Surgeon, National Guard Bureau (NGB/SG) should establish policy in ANGR 169-01, ANG Annual Medical Training Program, that clearly permits the units to use several days of annual training time for medical readiness. Another is to promote the establishment of a medical readiness training site and tailor the CMR training for ANG medical units. Finally, NGB/SG should obtain a SCPS-M training facility for the Air National Guard.

Chapter One

INTRODUCTION

Airmen seldom think of who will provide medical care during war as this is not a very pleasant thought, especially in time of peace. Chances are, the first medical personnel to provide care would be those assigned to the air base in the second echelon (2E) medical facility. Airmen would most likely be treated by Air National Guard (ANG) medical personnel. This is the major medical mission that the ANG accepted as its wartime tasking to support the U.S. Air Force. (11:--)

As the 2E mission begins implementation in the ANG, it is important to evaluate what medical readiness training requirements have evolved and means to accomplish this training. This paper explains the medical echelons of care, the impact of the 2E mission on the ANG, compares and evaluates training requirements, and makes recommendations on means to accomplish the training.

BACKGROUND

Medical care will be provided during war in two theaters of operations. These theaters are the Combat Zone (CBTZ) which is the land, sea, and air space required for combat operations and the Communications Zone (COMMZO) which is the land, sea, and air space needed to support the CBTZ. (5:2) The first and second echelons of care will be performed in the CBTZ and the third and fourth echelons of care are performed in the COMMZO. Each echelon of care is as follows:

First Echelon (1E) is first aid performed by the casualty (self aid) or by comrades (buddy care). This care includes administering nerve agent antidote, controlling hemorrhages, immobilizing fractures, protecting wounds, and performing limited decontamination. It will also be necessary, using expedient or improvised means, to assist the injured to the nearest casualty collection point, or to the next echelon.

Second Echelon (2E) is the first level where a casualty will encounter medical personnel. This care will be located as close as possible to the site where casualties occur. Emergency care will be provided to include decontamination, triage, and initiation of treatment such as intravenous fluid administration, hemorrhage control, providing an airway, protecting wounds, and inserting tubes. Patients not returned to duty will be transported to the other two echelons of care, third and fourth echelon.

Third Echelon (3E) is the first medical facility staffed and equipped to provide surgical care. This care is an extension of field medical care directed toward saving life and stabilizing seriously injured casualties. This permits further evacuation, and the return to duty of patients with less serious illnesses and injuries. The 3E medical facility will be located outside of the area where combat is threatened.

Fourth Echelon (4E) is where casualties will be given comprehensive medical care. Patients will be kept at this echelon throughout their recovery and if time permits their rehabilitation; otherwise, they will be evacuated to the continental United States. (7:12)

According to wartime planning, most Air Force casualties receive initial treatment by personnel at air bases with 2E medical facilities. (9:--) These 2E medical facilities are called Survivable Collective Protective System-Medical or SCPS-M. They are 8 feet high and 10 feet wide and are a series of reinforced concrete sections. They provide areas for medical personnel to accomplish chemical decontamination and treat patients and for storage. (1:6) The Surgeon General of the Air Force requested the ANG to construct a SCPS-M at a base in 1988 for use as a training asset. (10:--) This 2E tasking is the focus of the ANG medical mission and the impact of it is substantial. A short review of the previous medical unit tasking and times available provides a better basis of understanding for further discussion.

PREVIOUS TASKING AND AVAILABLE TIME

Prior to the ANG acceptance of the 2E medical mission, medical units were tasked to provide wartime medical support either as "stand alone units" or as augmentation to existing

medical units in USAFE. This support consisted of surgical capability. The manpower documents or unit type codes (UTC) were sized to 21 or 43 personnel. When the Air Force medical service changed to the 2E medical mission, ANG medical units were assigned against this wartime mission without any change in mission statement or personnel specialties. A critical factor is available unit training time.

Training time available to Air National Guard units is substantially less than full time active duty Air Force personnel. In 1903, the number of annual "drill" periods was 48 and summer encampment was set at 15 days (8:--) and remains unchanged today. A drill period is equivalent to a 4 hour block of time. These drill periods are commonly performed by the entire unit and combined to two periods per day. This is referred to as a unit training assembly (UTA). Every month normally includes two UTA's. Usually these days are on a weekend hence the term "drill weekend". Medical units are actually together (excluding summer encampment) 12 times per year. The majority of this time is used to perform peacetime support to the flying unit (about one and a half UTA's per month). (13:--) Therefore, peacetime requirements equate to 18 of the available 24 UTA's. The 15 days summer encampment (also referred to as annual training) is scheduled during the summer months for greatest personnel availability and is the time when the medical units deploy to an active duty medical treatment facility (MTF) for a minimum of 7 days in order that technicians receive medical skill training. (2:1) From the above background, we can examine the impact of the new 2E medical mission on the ANG.

Chapter Two

IMPACT ON THE ANG

The 2E medical mission was accepted by the Director of the Air National Guard in 1984 replacing six 250 bed hospitals originally programmed. This equates to ANG support for 67 of the 132 second echelon medical units required by the AF medical service in time of conflict. (11:--) This has had positive and negative impacts on the ANG medical mission.

On the positive side, the 2E unit manpower document was developed in conjunction with the medical readiness departments of the ANG, Air Force Surgeon General's office, Tactical Airlift Command Surgeon's office, and the Surgeon's office of the US Air Forces Europe (USAFE)

from 1982 to 1985. The result was a manpower document supporting wartime mission taskings of USAFE and allowing the ANG to use its unit program concept to fulfill the manpower requirements.

The unit type code (UTC) developed (FFGJ1) consisted of 72 personnel with substitutions that do not degrade medical skills to meet the wartime medical skills of Air Force Specialty Codes (AFSC), authorized in both officer and enlisted medical career fields. This was particularly useful for the initial 13 ANG medical units selected for this growth as many had over 100% of their authorized strength and many more waiting to join the medical unit. This continues to be a bonus in the future as the medical units are converted from their present UTC to the new 2E UTC.

Many personnel presently assigned in a specialty AFSC, such as 90252 (operating room technician), can also perform as a 90250 (medical technician). Another example is general surgeons substituted into family practice positions. This further assists a recruiter in filling vacancies by not requiring specific specialties from the civilian health care sector. Added benefits include additional personnel to support physical exams, immunizations, and other peacetime requirements. All these benefits were a boost for the units but some problems remain.

Three major problems were identified at the outset. One was where to place all the personnel upon assignment, another was how to report their readiness status and finally was the task of accomplishing ancillary and medical readiness training. Most wing commanders involved with the change in their medical units were quite amenable to find other space on the base near the medical facility until permanent structures could be furnished. Reporting the new readiness status created problems for some medical units that could not fill all their specialty authorizations (these involve technician skills that require up to two years to upgrade). These units were granted permission to delay reporting under the UTC FFGJ1. To identify the unit still had capability to respond to some types of contingencies, the effected unit continued reporting under their old UTC for the transition period. Training was and still is a problem area effecting readiness, whether the medical unit reported under the old UTC or the new UTC.

Two mandatory types of training were not part of a formal school offered by the Air Force - ancillary and medical readiness training. Ancillary training requirements

are identified in ANGR 50-012. Since ancillary training was scheduled in a base wide program, the new UTC personnel were automatically included in the program. If all ancillary training was scheduled for the medical unit at one time, it would take the equivalent of one half UTA period per year. With their remaining time the medical personnel needed to accomplish medical readiness training.

We can realize that the 2E medical mission in the ANG has created positive impacts to support the USAF medical wartime requirement and the ANG peacetime mission. The major negative impact remaining is medical readiness training. This problem area merits further discussion.

Chapter Three

MEDICAL READINESS TRAINING

BASIC REQUIREMENTS

Concern for medical readiness was aptly stated in 1985 by the House Appropriations Committee:

A trained, ready and prepared military medical system is a top priority item in any discussion of readiness of our military system. Without a means to care for our fighting forces, the United States loses its credibility with the American people, our adversaries, the military commander, and most importantly, the troops themselves. (6:90)

Medical readiness remains a high priority and this training has been implemented. The purpose of medical readiness training is to prepare medical forces to survive and function in a disaster or wartime environment. (7:30) The specific training requirements applicable to the ANG are identified in Air Force Regulation 160-25, Medical Readiness Planning And Training. Table 1 provides a listing of the type of training required with the exception of Combat Arms Training, an eight hour annual course. (4:13) Also not included is Continuing Medical Readiness Training (CMRT), a triannual program consisting of training in core individual and field medical skills. (7:32,38) Table 1 training takes 70 hours for unit completion. (14:--) CMRT requires three full days to complete (See Table 2 for a sample program). (7:47) It must be noted that when CMRT is accomplished, all training in Table 1 is also satisfied.

Therefore, in the year a unit performs CMRT (Table 2), it need not duplicate the other training (Table 1).

Cardiopulmonary Resuscitation - Refresher
Basic First Aid - Refresher
Nuclear Biological Chemical Medical Defense Training - Refresher
Disaster Preparedness Orientation
Disaster Casualty Control Plan and Contingency Support Plan
Concept of Operations Briefing
Medical Mission: Peacetime and Wartime Briefing
Management of Casualties in Medical Facility Training
Awareness of types of Disasters Briefing
Protection/Decontamination of Personnel, Patients, Equipment Training
Geneva Convention and Law of Armed Conflict Briefing
Mass Casualty Exercise
Combat Arms Training
Mobility Briefing
Mobility Processing
Telephone Alert Recall
Continuing Medical Readiness Training
Chemical Warfare Defense Ground - Refresher

Table 1. Recurring ANG Medical Readiness Training.
Source: AFR 160-25 (p 51)

FIRST DAY

0530-0630	Assemble and Distribute Field Gear
0630-0730	Concept of Operations
0730-0830	Geneva Convention and Law of Armed Conflict
0830-0900	Using Medical Intelligence
0900-0930	Site Selection
0930-1015	Tent Pitching Demonstration
1015-1200	Erect Tents
1200-1300	Lunch
1300-1400	Field Sanitation and Hygiene
1400-1500	Field Sanitation Devices
1500-1600	Principles of Area Defense
1600-1700	Map and Compass Lecture
1700-1900	Map and Compass Course (Practical)
1900-2000	Dinner
2000-2200	Triage Decision Model

SECOND DAY

0530-0600	Wake Up
0600-0700	Breakfast
0700-0900	Triage Practical Exercises
0900-1000	Chemical Warfare Defense
1000-1200	Chemical Warfare Ensemble and Confidence Chamber
1200-1300	Lunch
1300-1400	Nuclear Warfare
1400-1500	Biological Warfare
1500-1700	Patient Decontamination
1700-1800	Dinner
1800-2000	Bandaging and Splinting
2000-2100	Wartime Psychiatry

THIRD DAY

0530-0600	Wake Up
0600-0700	Breakfast
0700-0800	Field Command Post and Communication
0800-1000	Litter Obstacle Course (Patient Retrieval)
1000-1200	Patient Evacuation (Vehicle Loading)
1200-1300	Lunch
1300-1400	Mobility Processing
1400-1500	Prepare for Mass Casualty Exercise
1500-1630	Mass Casualty Exercise
1630-1700	Mass Casualty Exercise Critique
1700-1800	Strike Tents and Turn in Field Gear

Table 2. Sample Unit CMR Training Schedule.
Source: AFR 160-25 (p 47)

Medical readiness training is not just that identified above. Units must deploy overseas to their wartime location periodically, participate in mass casualty exercises, and base mobilization planning and processing exercises. (7:37) A review of the total time use for the many training requirements set down for the ANG medical units is appropriate.

TRAINING TIME SUMMATION AND ACCOMPLISHMENT

The ANG medical unit has 15 days annual training and 24 unit training assemblies (UTA's) each year. The 15 days of annual training are for deployment to the active duty medical treatment facility, overseas deployment (limited to 10 units per year due to budget constraints), and exercises (presently limited to 2 per year for the Honduras Medic 21 program). (12:--) The 24 UTA's are used as follows: 18 for peacetime support, .5 for ancillary training, leaving 5.5 UTA's or 44 hours to accomplish 70 hours of medical readiness training or three days of CMRT, combat arms training, participate in a mass casualty exercise, and base mobilization planning and processing. The disconnect between time available and requirements is obvious.

To date the ANG medical units typically manage their time wisely. Two documents, the Health Services Management Inspection (HSMI) Report and yearly unit after action reports, verify this capability. The HSMI reports are from the Inspection General's Air Force Inspection and Safety Center and were designed to inspect the management capabilities of ANG medical units. Beginning in October 1987, the focus changed to readiness and the team name was also changed to reflect this - Health Services Readiness Inspection Team.

An annual review of 41 ANG medical unit inspections revealed an overall 10.9% increase in management capabilities of both mobility and non-mobility units (satisfactory or better rating). (3:--) This shows progress in the overall medical programs; however, further review of the available data indicates problem areas in readiness training. Three areas identified directly with 29 mobility units tasked for the 2E mission are combat arms, chemical warfare task qualification training and chemical warfare training. They were rated 48%, 34%, and 27% respectively less than "satisfactory". (3:--) Extrapolating this information to 67 medical units tasked for 2E equals the following unsatisfactory unit ratings: 32 units in combat arms, 23 in chemical warfare task qualification training and 19 in chemical warfare training.

24.6 units would not meet the "real test": to survive and function effectively in a wartime situation.

The author reviewed many unit yearly after action reports over the past five years and several items were prevalent. Training was accomplished piecemeal by performing some of the readiness training at home station and some while on annual training status. All medical readiness training cannot be scheduled while on annual training status because the active duty MTF's do not have the time, personnel and facilities for every reserve unit to perform CMRT while they are at the active duty MTF. Meetings with ANG medical unit commanders revealed that; until the advent of the CMRT requirement and the realization of what the actual 2E mission with a SCPS-M facility entails, they could accomplish most medical readiness training. They are concerned how their units can get realistic training especially since only one SCPS-M is available (Spangdahlem AB, Germany). These after action reports, the Health Services Management Inspection reports, and meetings with commanders of the ANG medical units combined with the previous data provide thought provoking information on the medical readiness training in the ANG.

Chapter Four

CONCLUSIONS

The information presented on the ANG medical readiness mission and its training has enlightened us in several areas. Explaining the wartime echelons of care concept aided our understanding of the impact on the changes in the ANG medical tasking. This led us to the ancillary and medical readiness training requirements comparison with available time. The available time is 24 UTA's per year for drill and fifteen days per year for annual training. Of the 24 UTA's, only 5.5 UTA's or 44 hours are available for 70 hours of medical readiness training. This created a time management problem which appeared to be corrected as indicated by the Health Services Management Inspections ratings but closer review of these and yearly after action reports and medical unit commanders' comments, reveal a different scenario.

Further examination of the HSMI reports indicates that over 24 units would not be effective due to a lack of training in specific areas, especially in chemical warfare. After action reports and medical unit commanders identified problems accomplishing Continuing Medical Readiness training and SCPS-M facility training. These problem areas in

medical readiness training must be corrected.

RECOMMENDATIONS

This paper recommends actions to provide ANG medical units with the means to accomplish their readiness training. One recommendation is to establish policy in ANGR 169-01, ANG Annual Medical Training Program, that clearly permits the units to use several days of annual training time for medical readiness training. Another is to promote the establishment of a medical readiness training site and tailor the CMRT Sample Schedule at Table 2 for ANG medical units. A final recommendation is to obtain the SCPS-M training facility for the Air National Guard.

Establishing annual training time for medical readiness training as policy in ANGR 169-01 is within the auspices of the Office of the Air Surgeon, National Guard Bureau (NGB/SG). The Chief, Medical Plans and Readiness assigned to the Air Surgeon's office is the office of primary responsibility. (2:1) Doing this makes a clear statement of the importance placed on readiness and provides the units the necessary additional time to complete the 70 hours of medical readiness training. The training must be realistic and this requires the appropriate environment.

Realistic CMRT must be in field conditions as indicated in AFR 160-25 and an appropriate site should be developed. The site requires facilities and tailoring it to accomplish ANG CMRT medical unit needs. NGB/SG should coordinate this action within the National Guard Bureau Directorate to determine feasibility, costs, and if existing resources are available. This site selection would be one of the ways to develop an appropriate environment. Another way is the SCPS-M.

The offer by the USAF Surgeon General to place a SCPS-M at an Air National Guard site should be accepted. Naturally, coordination of specific site requirements, costs, staffing, etc., must be accomplished. Obtaining the SCPS-M provides the means for medical personnel to train in the wartime facility they will be using (realism). This definitely contributes to the ANG medical readiness status.

All these recommendations contribute to the ANG medical units' readiness status. A change in the annual training policy for medical readiness training requirements can be accomplished by regulation change and distribution. The medical readiness training site and the SCPS-M facility site

are projects which may take from a year to five years to complete depending on resource needs and budgeting constraints. One important point is to not have the medical readiness training site reliant on the acceptance and establishment of the SCPS-M. These actions should be considered independent but would be best if located together and accomplished simultaneously. Completing these recommendations provides the means to accomplish the medical readiness training requirements in the Air National Guard.

A trained and ready ANG medical unit will survive wartime conditions. This will support the USAF wartime medical mission; however, more importantly it increases the credibility of our military medical system. This credibility transcends to Americans, adversaries, commanders and to the key personnel in war - the troops!

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